

Commonwealth of Virginia

Health Benefits Program

Enrollment Form For Active Employees

Detailed health benefits and Flexible Reimbursement Account information, including the EmployeeDirect health benefits enrollment system, is available on the Department of Human Resource Management's (DHRM) Web site at www.dhrm.virginia.gov/compandbenefits.html. If you choose to use this form, return it to your agency Benefits Administrator within the following time periods: 1) by the end of the Open Enrollment period, or 2) within 31 days of eligibility or an event allowing changes outside Open Enrollment. Please refer questions about this form to your Benefits Administrator.

ENROLLING AS A NEW EMPLOYEE

- *Health Coverage*

As a newly-eligible employee, you may select a health benefits plan, additional coverage options and type of membership. You must be at work on the effective date of coverage to be eligible for health benefits. To enroll, complete parts A through E. If you choose to waive coverage, complete Parts A, C, and E.

- *Paying Premiums*

Health coverage premiums are deducted automatically from paychecks before taxes.

- *Flexible Reimbursement Accounts (FRAs)*

Newly-eligible employees may enroll in a Dependent Care FRA by completing Part D. However, there is a six-month waiting period for enrollment in a Medical FRA. You must enroll in a Medical FRA in the 31-day period prior to completing your sixth month of eligibility for the health benefits program. Complete Parts A, B, D and E.

OPEN ENROLLMENT

- *Health Coverage*

Once enrolled, you may change your plan, additional coverage options and type of membership during the annual Open Enrollment period. To make a change during Open Enrollment, complete Parts A, B, C and E.

- *Flexible Reimbursement Accounts (FRAs)*

There is an Open Enrollment period each Spring for electing FRA participation. Complete Parts A, B, D and E.

CHANGES OUTSIDE OPEN ENROLLMENT

- *Health Coverage*

You may change membership if you experience an event that permits an election change outside Open Enrollment (qualifying mid-year event). Complete Parts A, B, C and E.

- *Flexible Reimbursement Accounts (FRAs)*

You may change your FRA election if you experience a consistent qualifying mid-year event. Complete Parts A, B, D and E.

ENROLLING IN OTHER THAN ACTIVE COVERAGE

- *Enroll in VSDP – Long Term Disability*

Employees receiving benefits from the Virginia Sickness and Disability Program – LTD (not working) must complete a separate Enrollment Form for Retirees (#T20334) available from your Benefits Administrator. When returning to work from VSDP, see your Benefits Administrator.

- *Enroll as Retiree/Survivor*

There is a separate Enrollment Form (#T20334) for retirees. If you need a copy, please contact the Virginia Retirement System, your Benefits Administrator or visit the Department of Human Resource Management's Web site.

- *Enroll in Extended Coverage*

You may enroll in Extended Coverage by completing a separate form (#T20336) available from your Benefits Administrator or on the Department of Human Resource Management's Web site.

PART A: Employee Information

PLEASE PRINT

Name _____ Social Security Number _____
First Name M.I. Last Name

Address _____
Street City State Zip

Work Phone: (_____) _____ Home Phone: (_____) _____ Sex: ☐ Male ☐ Female Date of Birth _____
MM/DD/YYYY

Work E-mail Address _____ Home E-mail Address _____

CURRENT STATE ENROLLMENT: Are you or any member of your family now covered by one of the State health benefits plans?

☐ Yes ☐ No If yes, give Agency Name _____

PART B: Reason(s) For Submitting Enrollment Form

Contact your Benefits Administrator for benefit effective dates.

(Check all that apply)

☐ **Newly-Eligible Employee:** Date _____ (includes rehire after 30 days)
☐ Health Coverage (01) ☐ Dependent Care FRA (01) ☐ Medical FRA (after 6-month waiting period) (25)

☐ **Open Enrollment:**
☐ Health Coverage (56) ☐ Flexible Reimbursement Account(s) (56)

☐ **Changes Outside Open Enrollment** (indicate event below)
☐ Health Coverage ☐ Flexible Reimbursement Account(s)

☐ **Add / Remove** (circle one and list all names below)

QUALIFYING MID-YEAR EVENTS (Check one) Date of Event: _____

Employment Change that Affects Eligibility

- ☐ Employee begins leave without pay or family medical leave (49)
- ☐ Employee returns from leave without pay or family medical leave (50)
- ☐ Spouse or covered child gains employer eligibility (including switching from part-time to full-time employment) (28)
- ☐ Spouse or eligible child loses employer eligibility (including switching from full-time to part-time employment) (13)
- ☐ Spouse begins leave without pay (64)
- ☐ Spouse ends leave without pay (63)

Legal Marital Status Change

- ☐ Marriage (07)
- ☐ Divorce (10)
- ☐ Death of spouse (08)

Judgments, Decrees or Orders

- ☐ A court has required that another party cover your children (67)
- ☐ Judgment, decree or order requiring coverage of a child (71)
- ☐ Social Services order requiring coverage of a child (33)

Medicare or Medicaid Change

- ☐ Dependent gaining eligibility for Medicare or Medicaid (66)
- ☐ Losing eligibility for Medicare or Medicaid (09)

Number of Eligible Family Members Change

- ☐ Adoption (16)
- ☐ Birth (15)
- ☐ Covered child ceases to be eligible (exceeds plan's age limit, marries, becomes self-supporting, etc.) (38)
- ☐ Death of a covered child (17)
- ☐ Permanent custody granted (72)

Changes Due to Special Circumstances

- ☐ HIPAA special enrollment due to loss of coverage (70)
- ☐ Losing eligibility under another government-sponsored plan (76)
- ☐ Employee or dependent moves in or out of a plan's service area (05)

Cost and/or Coverage Changes

- ☐ Day care provider or cost of day care change (for Dependent Care FRA only) (61)
- ☐ Open Enrollment or significant change under another employer's plan (62)

PART C: Health Coverage

I. TYPE OF MEMBERSHIP (check one)

☐ Employee Single (S) ☐ Employee Plus One (D) ☐ Family (F) ☐ Waive (W)

II. HEALTH PLAN (check one)

Self-Funded Statewide Plan

Administered By the State Health Benefits Program

- ☐ COVA Care Plan (CC0)
☐ COVA Care + Out-of-Network (CC1)
☐ COVA Care + Expanded Dental (CC2)
☐ COVA Care + Out-of-Network + Expanded Dental (CC3)
☐ COVA Care + Vision + Hearing + Expanded Dental (CC4)
☐ COVA Care + Out-of-Network + Vision + Hearing + Expanded Dental (CC5)

Regional Fully Insured HMO (Northern Virginia only)

- ☐ Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. – HMO (KP)

**Note: Kaiser plan members must 1) live or work in the Kaiser service area to enroll and 2) select a primary care physician.*

Be sure to use providers or facilities that participate in your plan's provider networks.

III. PAYING PREMIUMS

Please indicate monthly premium amount \$ _____.

IV. FAMILY MEMBERS TO BE COVERED (list all)

Relationship Codes: H=husband W=wife S=son D=daughter SS=stepson SD=stepdaughter OF= other female child* OM=other male child*

Name (include last name if different) PLEASE PRINT	Sex Code (M/F)	Birthdate MM/DD/YYYY	Social Security Number	Relationship Code
SPOUSE				
CHILDREN				

If you need more space, list additional children on a separate sheet of paper and attach to this Form.

*Attach explanation. Eligibility must be verified by your Benefits Administrator.

When adding an adult disabled child, see your Benefits Administrator.

PART D: Flexible Reimbursement Accounts (FRAs)

Please indicate which reimbursement account(s) you wish to select by entering your per pay period election amount(s) below. Participation in a Medical Reimbursement and/or a Dependent Care Reimbursement Account requires a new FRA election each plan year. A worksheet is available in the Flexible Benefits Sourcebook and on the DHRM Web site.

MEDICAL REIMBURSEMENT ACCOUNT

Maximum: Contact your Benefits Administrator.

Minimum: \$10 per pay period.

☐ Contribution per pay period (in whole dollars): \$ _____

DEPENDENT CARE REIMBURSEMENT ACCOUNT

Maximum: Contact your Benefits Administrator.

Minimum: \$10 per pay period

☐ Contribution per pay period (in whole dollars): \$ _____

PART E. Certification

ENROLLEE STATEMENT: Upon enrollment in the State Health Benefits Program, I acknowledge that the cost of coverage I elect shall be payroll deducted on a pre-tax basis. Payment of premiums is based on a monthly amount and partial payments are not allowed. Once enrolled, I understand that changes may only be made at Open Enrollment or with qualifying mid-year events (see Part B) when the changes are consistent with the events. I further understand that notice of cancellation of coverage does not relieve me from my obligation to pay the entire monthly premium for any month of coverage already begun. If the entire monthly premium is not paid, coverage will be terminated and any partial amounts paid will be forfeited. I am aware that the Commonwealth reserves the right to change my coverage to the appropriate plan and membership based on my eligibility and/or plan availability. I understand that non-payment of premium will result in cancellation of coverage.

FLEXIBLE REIMBURSEMENT ACCOUNTS: I certify that I am eligible for the benefit for which I am electing to participate, and hereby authorize the deduction of the elected contributions as indicated above for the duration of the plan year. I understand that this election cannot be revoked, changed, or modified during the plan year unless the revocation and new election are on account of, and consistent with, a qualifying mid-year event, as provided by the plan. I also understand that any amounts remaining in my account(s) not used for qualifying expenses during the plan coverage period for which I am enrolled, will be forfeited in accordance with the current plan provisions and tax laws. I certify that: 1) I will only use my FRA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plans before seeking reimbursement from my FRA, 3) I will not seek reimbursement through any other source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

CERTIFICATION/AUTHORIZATION: I certify that I have reviewed the information on this enrollment form and that it is complete and accurate to the best of my knowledge. Furthermore, I understand that the health plan and its business associates have the right to use Protected Health Information in connection with the treatment, payment and operations of these plans as defined by the Health Insurance Portability and Accountability Act.

Print Name _____ Social Security Number _____

SIGN HERE _____ Date _____

Agency Approval/Verification

I certify that I have reviewed this Enrollment Form and that it is complete and accurate to the best of my knowledge.

Agency Name _____ Agency No. _____ Effective Date _____
MM/DD/YYYY

Agency Representative's Signature _____ Date Received _____
MM/DD/YYYY

Print Name and Title _____ Phone No. _____

(Data Entry Note: BES Codes are included with this form in parenthesis.)